

BODYFIT PHYSICAL THERAPY AND WELLNESS
PATIENT HISTORY

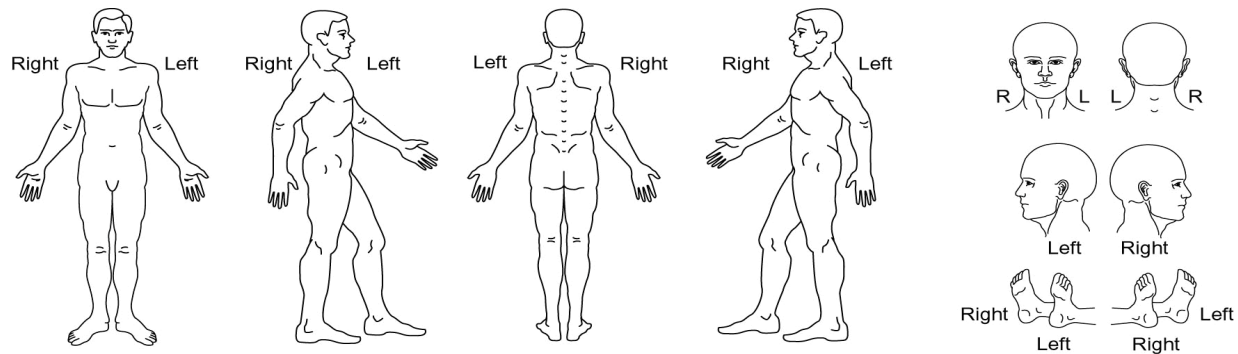
Last Name _____ First Name: _____

What is your chief complaint? _____

Rate your chief complaint in order of severity from 1 (least severe) to 10 (most severe)

Pain ____ Decreased Motion ____ Swelling ____ Stiffness ____ Loss of function ____

Where is your problem? (Indicate on body chart below) O= Pain, X= Numbness/tingling



Indicate the nature of your symptoms (circle all that apply):

Sharp Dull Stiff Shooting Aching Deep Boring Stabbing Tingling Numb Burning
Constant Intermittent

Onset of symptoms: _____ What happened? _____

What makes your symptoms worse _____

Are your symptoms: Improving? Stable? Worsening?

Have your symptoms affected your daily life/routine? _____

What, if any, treatment have you received for this problem? _____

Did this treatment help _____

General Medical History

Do the current symptoms interrupt your sleep?	Yes	No
Do your symptoms change with coughing or sneezing?	Yes	No
Have you had any recent changes in bowel or bladder function?	Yes	No
Do you experience any dizziness or vertigo?	Yes	No
Have you had any recent change in your weight or appetite?	Yes	No
Do you have any intolerance to hot or cold?	Yes	No
Do you have any bruising or bleeding disorders?	Yes	No
Have you had any skin changes such as rashes or discoloration?	Yes	No
Have you experienced any recent vision change (blurred, double vision)?	Yes	No
Have you had a recent episode of nausea or vomiting?	Yes	No
Are you pregnant?	Yes	No
Do you have osteoporosis?	Yes	No
What was the date of your last bone scan? _____		
Do you have any allergies or asthma?	Yes	No
If yes please specify: _____		
Do you have any cardiac problems?	Yes	No
Have you noticed any shortness of breath or decrease in exercise tolerance?	Yes	No
Do you have high blood pressure?	Yes	No
Do you have diabetes?	Yes	No
Do you have a history of cancer?	Yes	No
Do you have a history of neck or back problems?	Yes	No
Are there any other conditions or illnesses that we should be aware of?	Yes	No
If so, please specify: _____		
List any past surgeries that you have had: _____		
List all medications that you are presently taking: _____		
